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Y 000	Initial Comments This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 9/9/08 and completed on 10/14/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was four. Four resident files were reviewed and three employee files were reviewed. The facility did not have discharged resident files onsite for review. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	Y 000		
Y 072 SS=F	449.196(3) Qualications of Caregiver-Med re-training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination	Y 072		

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Y 072	Continued From page 1 relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Based on record review on 9/9/08, the facility did not ensure 3 of 3 caregivers had the required three hour medication management refresher training every three years (Employee #1, #2, #3). Findings include: Employees #1 and #2 received four hours of medication re-training on 6/17/05. Their files did not contain evidence they completed at least three hours of medication refresher training by 6/17/08. Employee #3 completed medication training on 7/14/04 and had no evidence of any additional medication training since that time. Severity: 2 Scope: 3	Y 072		
Y 152 SS=A	449.204(2) Insurance-BLC endorsement NAC 449.204 2. A certificate of insurance must be furnished to the Division as evidence that the contract required by subsection 1 is in force and a license must not be issued until that certificate is furnished. Each contract of insurance must contain an endorsement providing for a notice of 30 days to the bureau before the effective date of a cancellation or nonrenewal of the policy.	Y 152		

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Y 152	Continued From page 2 This Regulation is not met as evidenced by: Based on interview on 9/9/08, the facility could not provide evidence of a current policy of liability insurance. Findings include: The administrator reported she did not have a copy of the facility's Certificate of Liability Insurance at the facility. Severity: 1 Scope: 1	Y 152		
Y 207 SS=F	449.211(4)(b) Automatic Sprinklers-Annual Inspections NAC 449.211 4. An automatic sprinkler system that has been installed in a residential facility must be inspected: (b) Not less than once each calendar year by a person who is licensed to inspect such a system pursuant to the provisions of chapter 477 of NAC. This Regulation is not met as evidenced by: Based on observation on 9/9/08, the facility did not ensure the automatic fire sprinkler system had been inspected for the last two years. Findings include: The inspection tag on the facility's automatic fire sprinkler system was dated 7/20/06. The facility did not have evidence of inspections in 2007 or 2008.	Y 207		

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Y 207	Continued From page 3 Severity: 2 Scope: 3	Y 207		
Y 272 SS=C	449.2175(3) Service of Food - Menus NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days. This Regulation is not met as evidenced by: Based on observation and interview on 9/9/08, the facility did not ensure dated menus were posted and kept on file for review for 90 days. Findings include: The menu posted on a bulletin board in the kitchen was undated and there was no evidence of any other menus being used by the facility. The administrator reported their menus were not dated and no copies of past weekly menus were being kept by the facility. Severity: 1 Scope: 3	Y 272		
Y 432 SS=C	449.229(2)(b) Plans for Evacuation NAC 449.229 2. A residential facility shall have a plan for the evacuation of resident in case of fire or other emergency. The plan must be: (b) Posted in a common area of the facility. This Regulation is not met as evidenced by: Based on observation on 9/9/08, the facility did	Y 432		

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Y 432	Continued From page 4 not ensure complete plans for evacuation were posted in the facility. Findings include: Floor plans of the facility were posted in bedrooms and living areas of the facility but routes showing directions to go to evacuate the areas were not drawn on the plans. Severity: 1 Scope: 3	Y 432		
Y 590 SS=H	449.268(1)(a) Resident Rights NAC 449.268 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility. This Regulation is not met as evidenced by: Based on interviews and record review from 9/9/08 to 10/9/08, the facility failed to ensure a caregiver was not verbally and emotionally abusive to 2 of 4 residents (Resident #2 and #4). Findings include: Interviews with residents were conducted on 9/9/08. The four residents at the facility demonstrated varying levels of cognition. Resident #3 refused to talk to the surveyors. Residents #1 and #2 were limited in their ability to	Y 590		

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converse with the surveyor.

Resident #4 communicated well and was well aware of herself, her surroundings, the time of day and time of year. She reported she was having difficulties with Employee #3, who was the primary caregiver at the facility. The resident used a wheelchair and related that she required the assistance from the caregiver to transfer from the wheelchair to her bed and to a toilet. She reported she knows when she needs to go to the bathroom and could remain continent if the employee would get her to the toilet in time. She stated there had been occasions when he has told her to wait because he did not want to take her yet.

Resident #4 related that Employee #3 acted like he was angry with her when she asked him questions; that the employee kept candy brought by her son in the refrigerator and has refused to give it to her; that the employee has threaten to not let her son visit her; and that the employee used to give her juice and soda pop along with water at meals, but now refuses to give her anything but water and the resident is not on a restricted diet. The resident stated that she likes to go to bed between 8:30 - 9:00 PM, but the employee has put her in her bed as early as 6:30 PM. The resident said that when she complained to the employee he told if she did not go to bed when he took her, she would have to sit in her chair all night because he was not coming back to get her. The resident reported when she then woke up too early in the morning, the employee told her to shut-up and go back to sleep.

Resident #4 had a friend at the facility the day of the survey. The friend stated she has heard Employee #3 "hollering" at other residents in their rooms while she visited with the resident and that she has seen the employee come up behind the

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resident and clap his hands beside her ear as if to try to scare her. The resident and friend related that the employee was very strict about the facility visitation hours, which were 9:00 AM to 12:00 PM and 1:00 PM to 6:00 PM. The resident's son worked late most days and had a difficultly visiting within these hours. The resident reported her son took her out to dinner recently and they did not return until after 7:00 PM. The employee told them he would lock them out of the facility if they came late again.

Both Resident #4 and the resident's friend reported Employee #3 napped regularly on the living room couch in the afternoon. The resident stated the employee has occasionally told her she needed to nap too and put her in her bed, even though she said she did not want to go to bed. The friend related she has had to wake Employee #3 up from his nap because the resident needed something from him. The friend reported the employee complained to her recently that he work 24 days straight without a day off and that one of the male residents was keeping him up all night. The resident commented that there were days she laid in bed until 9:00 AM because the employee said he was too tired to get her up.

Resident #4 reported that she has been tipping Employee #3 $100 to try to get better care and believed others in the facility were tipping also. The resident's friend stated the employee complained a lot about being poor and needing more money to send to his family in the Philippines. The resident mentioned that she did not think the owners knew the employee was accepting tips. The friend and resident reported they were trying to find another living arrangement and feared the resident would be treated worse if Employee #3 found out they were complaining about him.

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Y 590	Continued From page 7 Family members and/or friends of Residents #1, #2, #3 and #4 provided information to the Bureau or were interviewed over the phone between 9/23/08 and 9/25/08. The contact for Resident #1 stated the facility was clean, had good food, and could not think of anything being wrong. The contact did mention that Employee #3 could be "a little curt" with residents if he was in the middle of something. The contacts for Residents #2 and #3 had no complaints about Employee #3 and stated he was doing a good job. The contact for Resident #3 reported the resident had a bank account and this person would take him to the bank or would withdraw money from the account for him and bring it to him at the facility. The contact stated the resident usually took $100 out of his account and that he liked to buy things or give money to people, but did not know who he gave money too. Resident #4's son was interviewed on 9/25/08 and he stated that Employee #3 seemed to do a good job and could be very nice but had also been very rude to him. The son related that he brought the resident back to the facility at 7:40 PM one night and the employee made them wait outside for five minutes before opening the door. The son stated his mother told him that the employee would sometimes make to wait before taking her to the bathroom. He reported that he had also heard the employee yelling at Resident #2, calling her stupid and telling her he would get to her when he could. He stated he gives his mother $100 each month for things like shopping and that she is in control of what she does with the money. The son related his mother told him she has tipped Employee #3 because she thought it makes him treat her nicer. Employee #3's work schedule was discussed with the administrator, Employee #1, and her	Y 590		

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Y 590	Continued From page 8	Y 590		

husband, Employee #2 on 9/9/08. Both stated Employee #3 told them he liked to work at the facility because he liked earning the money and that he often requested to work on his scheduled days off. The administrator reported she was out of the country for three to four weeks recently and Employee #3 covered her shifts and did not have a day off. The 2008 resident medication administration records (MARs) showed Employee #3 initialed giving medications to residents nine out of nine day in September (9/1-9/08), 31 out of 31 days in August, 28 out of 31 days in July, 30 out of 30 days in June, 30 out of 31 days in May and 28 out of 30 days in April. The records would indicate Employee #3 was away from the facility only six days in the last six months.

Review of Employee #3's file on 9/9/08 revealed the employee was hired in August of 2007. The employee completed medication administration training in 2004 but had not attended any re-training in the last three years. The facility had not completed a criminal background check on the employee and there was no evidence of training in the file beyond first aid and cardiopulmonary resuscitation (CPR) training in 2006.

A meeting was held with Employee #2, owner of the facility, on 10/9/08. The owner was informed of the allegations that Employee #3 was verbally and emotionally abusing at least two residents at the facility. The owner stated he had not been made aware of these issues by the residents or their families and had not witnessed this type of behavior by the employee. The owner reported Employee #3 would be given a termination notice and notice to move out of the facility by 10/12/08. The owner was instructed to provide a plan to ensure the residents would be safe from abuse and possible retaliation until the

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Y 590	Continued From page 9 employee moved out of the facility. The plan submitted by the owner at 5:00 PM on 10/12/08 indicated another caregiver would be present in the facility at all times Employee #3 was in the facility. The owner reported Employee #3 would not be informed about the resident's complaints and would be told his termination was due to failure to attend required caregiver training to prevent possible retaliation. Severity: 3 Scope: 2	Y 590		
Y 859 SS=C	449.274(5) Periodic Physical examination of a resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. This Regulation is not met as evidenced by: Based on record review on 9/9/08, the facility failed to ensure 1 of 2 residents, who resided in the facility for more than one year, met the annual physical requirement (Resident #3). Findings include: Resident #3: The resident was admitted on 1/3/05. The last annual physical in the resident's	Y 859		

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Y 859	Continued From page 10 file was dated 8/9/07 and there was no evidence of a physical for 2008. Severity: 1 Scope: 3	Y 859		
Y 870 SS=C	449.2742(1)(a)(1) 449.2742(1)(a)(1) Medication Administration NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. This Regulation is not met as evidenced by: Based on record review on 9/9/08, the facility failed to ensure medication regimen reviews were completed every six months on 2 of 2 residents who resided in the facility for more than six months (Resident #2, #3). Findings include: Resident #2 was admitted to the facility on 9/21/07. Review of the resident's medications were completed on 8/21/07 and 12/16/07. There was no evidence a medication review was	Y 870		

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Y 870	Continued From page 11 completed in June of 2008. Resident #3 was admitted on 1/3/05. Medication reviews were completed in August 2006 and August 2007, one year apart. There was no evidence in the file that any medication reviews were completed in 2008. Severity: 1 Scope: 3	Y 870		
Y 878 SS=F	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review on 9/9/08, the facility failed to ensure that 2 of 4 residents received medications as prescribed (Resident #1 and #2). Findings include: Resident #1: The resident had a prescription bottle labeled for Remeron 15 mg tablets, one tablet at bedtime. The medication was not listed on the September 2008 medication	Y 878		

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Y 878	Continued From page 12 administration record (MAR). There was no discontinue order from the physician in the resident's file. The resident was also prescribed Trazodone 100 mg, 1/2 tablet at bedtime for three days at bedtime, then one at bedtime as needed (PRN) for sleep. The instructions written on the resident's September 2008 MAR indicated the medication was to be given every night at bedtime instead of as a PRN. The medication was documented as given at bedtime from 9/1/08 to 9/8/08. Resident #2: The resident was prescribed Haldol 5 mg, one tablet two times a day, on 7/28/08. The prescription bottle labeled for Haldol reflected the same order. The resident's September 2008 MAR listed the prescription as Haldol 1/2 tablet two times a day, and the August 2008 MAR showed the change in dosage began on 8/13/08. There was no physician's order for a change in the Haldol dosage in the resident's file. Resident #2 also had a prescription bottle labeled for Alprazolam 0.25 mg, one tablet three times a day PRN. The resident's August and September 2008 MARs listed the Alprazolam to be given as a regularly scheduled medication three times a day. The medication was initialed as given at 8:00 AM, 12:00 PM and 5:00 PM everyday in August and from 9/1/08 to 9/8/08. Severity: 2 Scope: 3	Y 878		
Y 885 SS=F	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility	Y 885		

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Y 885	Continued From page 13 shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication. This Regulation is not met as evidenced by: Based on observation and interview on 9/9/08, the facility did not destroy medications after 4 of 4 residents were discharged from the facility (Resident #5, #6, #7 and #8) and did not destroy a medication for 1 of 4 residents at the end of the prescribed dosing period (Resident #4). Findings include: The facility did not have the files for discharged Residents #5, #6, #7 or #8 in the facility for determination of a discharge dates. The following medications for the discharged residents were found in kitchen cupboards with employee medications and in the refrigerator and the closet where resident medication where stored. The medications were not destroyed after the residents left the facility: Resident #5: - Risperdal 0.5 milligrams (mg) filled on 5/8/08 for 30 tablets. Six tablets remaining in the container. - Risperdal 0.5 mg filled on 5/22/08 for 30 tablets. Twenty-nine tablets remaining. - Clonazepam 0.5 mg filled on 5/8/08 for 22-1/2 tablets. Fourteen 1/2 tablets remaining.	Y 885		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HOME CARE OF NV	3856 JEWEL AVE. LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 885	Continued From page 14 - Clonazepam 0.5 mg filled on 5/22/08 for 22 tablets plus one 1/2 tablet. Forty-five-1/2 tablets remaining. Resident #6: - Seroquel 100 mg filled on 11/19/07 for 30 tablets. Twenty-one tablets remaining. - Seroquel 50 mg filled on 11/6/07 for 30 tablets. Thirty-six tablets in the bottle. - Bisacodyl 10 mg filled on 9/22/07 for 12 suppositories. Ten suppositories remaining. Resident #7: - Metoprolol 50 mg filled on 4/17/08 for 60 tablets. Fourteen tablets remaining. Resident #8: - Furosemide 20 mg filled on 8/6/08 for 30 tablets. Twenty-three tablets remaining. - KCL 10 mEq filled 8/6/08 for 30 tablets. Thirteen tablets remaining. - Advair 250/50 and Atrovent inhalers, and Nasonex. Resident #4: The resident was prescribed Cyanocobalamin 1,000 mcg/ml, inject one milliliter in the mouth weekly for one month. The medication was filled on 4/7/08 and was written on the resident's April 2008 MAR. The medication was not destroyed at the end of the dosing period. Severity: 2 Scope: 3	Y 885		
Y 921 SS=F	449.2748(2) Medication Storage NAC 449.2748 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless	Y 921		

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Y 921	Continued From page 15 the refrigerator is locked or is located in a locked room. This Regulation is not met as evidenced by: Based on observation on 9/9/08, the facility failed to ensure that refrigerated medications and medications belonging to 3 of 3 residents were secured in a locked box (Resident #1, #3 and #6). Findings include: Resident #1's Xalatan 0.005% eye drops were stored unsecured in the kitchen refrigerator. Resident #3's Milk of Magnesia was stored unsecured in the kitchen refrigerator. Discharged Resident #6's Bisacodyl 10 mg suppositories were stored unsecured in the kitchen refrigerator. The following unlabeled bottles of medication were stored in a shelf on the door of the refrigerator: two bottles of Tylenol Cold Medications and a bottle of Cherry Phenaseptic throat spray. Severity: 2 Scope: 3	Y 921		
Y 936 SS=F	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of	Y 936		

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Y 936	Continued From page 16 chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment; documentation. (NRS 441A.120) 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall: (b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is sooner. (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his	Y 936		

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Y 936	Continued From page 17 designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) Based on record review on 9/9/08, the facility failed to ensure the files for 4 of 4 current residents (Resident #1, #2, #3 and #4) and 4 of 4 discharged residents (Resident #5, #6, #7 and #8) were available in the facility for review by the surveyors, that 3 of 4 residents met the initial tuberculosis (TB) testing requirements (Resident #1, #3 and #4) and that 2 of 2 residents met the annual TB testing requirements (Resident #2 and #3). Findings include: The administrator of the facility, Employee #1, reported the files for residents had been removed from the facility so they could be updated by her and her husband, Employee #2. Employee #2 had to drive across town to one of their other licensed facilities to pick up the files for Residents #1, #2, #3 and #4. Employee #2 left before medications for discharged residents were found in the facility and the only records available for Residents #5, #6, #7 and #8 were past medication administration records. Resident #1: The resident was admitted on 8/5/08. The resident's two-step TB test was not initiated until 8/14/07, nine days after admission.	Y 936		

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Y 936	Continued From page 18 Resident #2: The resident was admitted on 9/21/07. The resident's two-step TB test in the file was initiated on 5/24/07 and completed on 6/2/07. There was no evidence of an annual one-step TB test in the file. Resident #3: The resident was admitted on 1/3/05. A two-step TB test was completed on 1/25/07 and there was no evidence of an annual one-step TB test by January of 2008. Resident #4: The resident was admitted on 3/25/08. The resident's two-step TB was not initiated until 5/2/08, 38 days after admission, and it was negative. A second-step TB test was initiated on 5/9/08 and a test result was not documented on the form, so the test was not completed. Severity: 2 Scope: 3	Y 936		
YA106 SS=F	449.200(1)(2)(3)Personnel Files NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his employment at the residential facility; (c) Records relating to the training received by the employee; (d) The health certificates required pursuant to chapter 441 of NAC for the employee; (e) Evidence that the references supplied by the employee were checked by the residential facility; and (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive.	YA106		

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YA106	Continued From page 19 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; and (b) Proof that the caregiver is 18 years of age or older. 3. The administrator may keep the personnel files for the facility in a locked cabinet and may, except as otherwise provided in this subsection, restrict access to this cabinet by other employees of this facility. Copies of the documents which are evidence that an employee has been certified to perform first aid and cardiopulmonary resuscitation and that the employee has been tested for tuberculosis must be available for review at all times. The administrator shall make the personnel files available for inspection by the Bureau within 72 hours after the Bureau requests to review the files. This Regulation is not met as evidenced by: Based on review of employee records on 9/9/08 and 9/11/08, the facility failed to ensure files for 3 of 3 employee were available for surveyor review when requested (Employee #1, #2 and #3) and failed to provide a complete file with mandatory requirements for 3 of 3 employees (Employee #1, #2 and #3). Findings include:	YA106		

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YA106	Continued From page 20 The administrator, Employee #1, was asked for the files of all employees for review at the beginning of the survey on 9/9/08. The administrator stated the files had been removed from the facility for updating. Her husband, Employee #2, drove across town to one of their other facilities to pick up the files. When Employee #2 returned, he provided files for himself and the administrator. During interviews, residents talked about a third employee, Employee #3. When the administrator was questioned about Employee #3, she reported she was in the process of hiring the employee, that he was not working at the facility yet and she did not have a file started on the employee. During review of resident medication administration records (MARs), Employee #3's initials were noted to be on the April through September 2008 MARs. Employee #3's signatures were also on the medication receipt logs from February through May 2008 and the logs from July through August 2008. The administrator changed her story when confronted with the documents and said Employee #3 had been recently fired. Employee #3 initialed the resident MARs at 9:00 AM on the day of the survey, 9/9/08. A resident's friend reported seeing the employee working at the facility the previous day. The administrator admitted she lied about the employee working at the facility because she could not find the employee's file and she knew she had not ensured the employee met all the caregiver requirements. Employee #2 later found Employee #3's file in the facility. On 9/11/08, surveyors returned to the facility for additional record review. Employee #3 was working and he stated he started working at the facility in August of 2007. The employee's initials were noted on the November and December	YA106		

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YA106	Continued From page 21 2007 MARs of Residents #2 and #3. Employee #3 was hired in August of 2007. The file for the employee held a copy of a negative two-step tuberculosis (TB) test completed on 5/11/07. The file did not contain evidence of an annual one-step TB test in 2008. The file did not contain evidence of fingerprints or a criminal history background check. The files for Employees #1, #2 and #3 did not contain evidence of at least eight hours of training in the last 12 months. First aid and cardiopulmonary resuscitation (CPR) certifications for Employee #1 and Employee #2 expired on 9/2/08 and the certifications for Employee #3 expired in August of 2008 Severity: 2 Scope: 3	YA106		
YA908 SS=C	449.2746(2)(a-f)PRN Medication Record NAC 449.2746 2. A caregiver who administers medication to a resident as needed shall record the following information concerning the administration of the medication: (a) The reason for the administration; (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician.	YA908		

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YA908	Continued From page 22 This Regulation is not met as evidenced by: Based on review of the medication administration record (MAR) on 9/9/08, the facility failed to ensure documentation for as needed (PRN) medications was complete for 3 of 3 residents with PRN medications (Resident #1, #2 and #3). Findings include: Resident #1: The resident was prescribed Trazodone 100 mg, 1/2 tablet at bedtime. The facility was documenting administration of the medication regularly at bedtime, versus as a PRN. There was no documentation concerning the reason or result of the medication administration. Resident #2: The resident was prescribed Alprazolam 0.25 mg, one tablet three times a day PRN. The facility was documenting administration of the medication regularly at 8:00 AM, 12:00 PM and 5:00 PM, versus as a PRN. There was no documentation concerning the reason or result of the medication administration. Resident #4: The resident was prescribed Tramadol 50 mg, one tablet every four hours PRN, on 3/25/08. The medication was listed on the resident's April 2008 MAR as a PRN, but was not listed on the MARs for May, June, July, August and September 2008. The medication was available in the facility medication closet and there was no doctor's order to discontinue the medication. Severity: 1 Scope: 3	YA908		